SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Applications (KIC) WVB	SERFF Tr Num: HUMA-128309463	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H21.000 Health - Other	Co Tr Num: AR-12-006 KIC WVB	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Erin Hermsen, John Goodwin, Lisa Geary, Tina Huettl, Christi Conrad	Disposition Date: 05/01/2012
	Date Submitted: 04/26/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: SB Life Enhancement	Status of Filing in Domicile: Not Filed
Project Number: AR-12-006 KIC SBE	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: na
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 05/01/2012	
State Status Changed: 05/01/2012	Deemer Date:
Created By: Erin Hermsen	Submitted By: Erin Hermsen

Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Healthcare.gov ID:
Filing Description:
This is a new filing; the attached forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process.
Included with this submission are the following documents:
·Certificate of Readability; and
·Filing Fee of $200 ($50 per form).

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me via SERFF or by phone at (800) 558-4444 extension 5083.
State Narrative:

Company and Contact

Filing Contact Information

Erin Hermsen, Specialty Benefits Compliance Consultant	ehermsen@humana.com	
325 Reid Street	920-337-5083 [Phone]	
De Pere, WI 54115	920-632-0197 [FAX]	

Filing Company Information

Kanawha Insurance Company	CoCode: 65110	State of Domicile: South Carolina
210 South White Street	Group Code: 119	Company Type:
Lancaster, SC 29720	Group Name:	State ID Number:
(800) 635-4252 ext. [Phone]	FEIN Number: 57-0380426	

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	4 forms @ $50 each
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Kanawha Insurance Company	$200.00	04/26/2012	58650180

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2012	05/01/2012

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Disposition

Disposition Date: 05/01/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	100+ Employer Group Application	Approved-Closed	Yes
Form	2-99 Employer Group Application	Approved-Closed	Yes
Form	Group Employee and Individual App and Enrollment form 2-99 Employees	Approved-Closed	Yes
Form	Large Group Employee and Individual App and Enrollment form	Approved-Closed	Yes

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/01/2012	AR-71012-EA-LG 4/2012	Application/ Enrollment Form	100+ Employer Group Application	Initial			AR-71012-EA-LG-20120417.pdf
Approved-Closed 05/01/2012	AR-71012-EA-SB 4/2012	Application/ Enrollment Form	2-99 Employer Group Application	Initial			AR-71012-EA-SB-20120417.pdf
Approved-Closed 05/01/2012	AR-72000 4/2012	Application/ Enrollment Form	Group Employee and Individual App and Enrollment form 2-99 Employees	Initial			AR-72000-20120417.pdf
Approved-Closed 05/01/2012	AR-72001 4/2012	Application/ Enrollment Form	Large Group Employee and Individual App and Enrollment form	Initial			AR-72001-20120417.pdf

[100+] Employer/Group Application - Arkansas

[HUMANA]

FOR GROUP COVERAGE ([100+] ELIGIBLE EMPLOYEES) Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

[1-10]. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ Other (explain) _____		Date company established		Federal Tax ID
Nature of business/SIC code	Business phone number ( )		Business fax number ( )	
Do you have more than one location? ☐ No ☐ Yes				
Benefit Administrator/Management contact name:				
Phone number ( )	Fax number ( )	E-mail		
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)				
Billing contact name:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
Phone number ( )	Fax number ( )	E-mail		
[Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]				
[**For Workplace Voluntary Benefits:** Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _]				
[**Type of Billing:** ☐ Self Billed ☐ Listed Billed **Premium mode:** ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual]				

[1-10]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	[All	[Medical	[Dental	[Life	[Vision	[STD	[LTD	[Group Critical Illness	[Workplace Voluntary Benefits
A. Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees									
Number of employees:									
• waiving with other qualifying coverage									
• waiving without other qualifying coverage									
Number of employees to be enrolled	]	]	]	]	]	]	]	]	]

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify)_____
(if you prefer months, please select "Other" and specify the number of months)

Employee effective provision: [(On all plans, except STD and LTD, the employee termination date coincides with the effective date provision. STD/LTD is immediate.)]
[New ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]
[Rehire ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

[1-10]. ELIGIBILITY REQUIREMENTS (continued)

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ other:_____

Employee Eligibility by Class
According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, please provide prior group number and termination date:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan _____
Plan number _____(Assigned by Employer for use in filing IRS form 5500)

Do you wish to offer Domestic Partner Coverage? ☐ No ☐ Yes

Retiree information
For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age _____ Minimum years of service _____

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered					

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	Total employees

[Group Term Life,] [Short Term Disability,] [Long Term Disability,] and [Group Critical Illness] only

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	☐	
Increases/decreases requested by employee	☐	
Increases (with Evidence of Insurability) requested by employee	☐	
Decreases due to age	☐	

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee life	$	$	Spouse life	$	$
Employee STD	$	$	Basic group critical illness	$	$
Employee LTD	$	$	Buy-up group critical illness		

☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.

[W-2 Services Option (Please choose one)
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.]

[1-10]. COBRA/STATE CONTINUATION

Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Number of existing COBRA participants	Medical:	Dental:	Vision:
How many in COBRA election period	Medical:	Dental:	Vision:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

[1-10]. EMPLOYER CONTRIBUTION(S)

[**Medical only**: Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes
If yes, indicate amount funded $_____]
[**STD and LTD only**: Are employer contributions taxed in employee paychecks? ☐ No ☐ Yes]

Coverage Employer's contribution for:	[Medical	[Dental	[Vision	[Life	[Voluntary Life	[STD	[BUY UP STD	[LTD	[BUY UP LTD	[Workplace Voluntary Benefits	[Spending Account*
Employee	%	%	%	%	%	%	%	%	%	%	$
Employee/spouse	%	%	%	%	%	N/A	N/A	N/A	N/A	%	$
Employee/child	%	%	%	%	%	N/A	N/A	N/A	N/A	%	$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	N/A]	N/A]	%]	$]

[1-10]. PRIOR/CURRENT CARRIER INFORMATION

	[Medical	[Dental	[Life	[Vision	[STD	[LTD
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name						
Proposed termination date	]	]	]	]	]	]

[**Dental only:** Did prior dental coverage include orthodontia? ☐ No ☐ Yes]

[**For Workplace Voluntary Benefits - Existing coverage available to employees**
[Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date_____]
[CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date_____]]

[1-10]. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder AR-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

[a-g]. MEDICAL PLANS

Is this a SmartSuite selection? ☐ No ☐ Yes

Product specification:	Product specification:
Product specification:	Product specification:
Product specification:	Product specification:

☐ Health Care Flexible Spending Account (FSA) ☐ Dependent Care Flexible Spending Account (FSD) ☐ Health Savings Account (HSA)
☐ Personal Care Account offered with product specification:

Are there any disabled dependents over the age of 26 to be covered in this group? ☐ No ☐ Yes
If yes, please provide on a separate sheet of paper (reorder GN-52422): name of employee, dependent name, statement of disability/diagnosis from attending physician, dependency statement from employee and the current group carrier insuring the dependent.

To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period: (check all that apply)

- confined at home, in a hospital, or a treatment facility ☐ No ☐ Yes
- who incurred more than $25,000 of medical expenses in the last 12 months ☐ No ☐ Yes
- who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
- who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease ☐ No ☐ Yes

For any checked option, please complete the information below. Attach additional signed and dated sheets (reorder GN-52338), if necessary.

Member Status*	Age	Medical Condition/Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

* Member Status: E=Employee D=Dependent C=COBRA R=Retiree Class

[**Health Questionnaire for groups enrolling [100+] employees:** (check all that apply)

1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? ☐ No ☐ Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
   - confined at home, in a hospital, or in a treatment facility ☐ No ☐ Yes
   - who incurred more than $10,000 of medical expenses in the past 24 months ☐ No ☐ Yes
   - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
4. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	☐ No ☐ Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
• Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	☐ No ☐ Yes
• Cancer or cancerous tumor	☐ No ☐ Yes	• Heart or vascular disease or stroke	☐ No ☐ Yes
• Organ transplant (other than corneal)	☐ No ☐ Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334), if necessary.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment

* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?
☐ No ☐ Yes If yes, please explain:_____

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment?
☐ No ☐ Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.]

[a-g]. DENTAL PLANS (all group sizes)

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In ___% / / Out ___% / /	In ___% / / Out ___% / /
Deductible	In $ Out $	In $ Out $
Annual maximum	$	$
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite fillings for molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
[Oral Surgery Covered in Basic	☐ No ☐ Yes	☐ No ☐ Yes]
Open Enrollment	☐ No ☐ Yes	

[a-g]. LIFE (all group sizes) - Please refer to your proposal

Basic Employee Life and AD&D (AD&D only applicable to certain plans)

☐ Flat amount—indicate level: $_____ Increment (if applicable) $_____

☐ Salary plan—options are 1x to 6x salary, rounded to the next highest $1,000. Indicate salary level: _____ x salary

☐ Class schedule—no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

Rate Guarantee (only available with certain plans) ☐ 2 Year ☐ 3 Year

Age Reduction (only available with certain plans)

If you are also selecting Voluntary Life Age Reduction, age reduction values between Basic Employee and Voluntary Life must match.

☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Basic Dependent Life ☐ No ☐ Yes If yes, indicate volume amount ☐ $20,000/$5,000 ☐ $10,000/2,500 ☐ $5,000/$1,000

[**Voluntary Life**

Voluntary Employee Life ☐ No ☐ Yes If yes, do you want to select AD&D? ☐ No ☐ Yes

Voluntary Dependent Life (Available only when enrolled in Voluntary Life) ☐ No ☐ Yes

[**Age Reduction (only available with certain plans)**

If you are also selecting Basic Employee Age Reduction, age reduction values between Basic Employee and Voluntary Life must match.

☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____]

[Portability of coverage (Applicable to Voluntary Life only) ☐ No ☐ Yes]]

[a-g]. VISION PLANS (all group sizes)

	Plan 1	Plan 2
Plan name (as shown on your proposal)		

Vision Options (For groups 100+ with a custom vision plan, please list the in-network benefit options below.)

Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Exam / material copayment	/	/
Frame allowance		
Contact lens allowance		
Frequency		

[a-g]. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____ ☐ Incremental amount $_____
Weekly benefit minimum	$_____
Weekly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other_____
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (accident/sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/3/12 ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____ ☐ Incremental amount $_____
Weekly benefit minimum	$_____
Weekly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other_____
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (accident/sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/3/12 ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

[a-g]. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Incremental amount $_____
Monthly benefit minimum	☐ $100 or 10% of monthly salary ☐ Other _____
Monthly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other_____
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

[a-g]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Incremental amount $_____
Monthly benefit minimum	☐ $100 or 10% of monthly salary ☐ Other _____
Monthly benefit maximum	$
Earnings definition	☐ Base salary ☐ Average _____ months bonus ☐ Average _____ months commission ☐ Other_____
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 3/12 ☐ 6/12 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Additional benefits: Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ☐ Lesser of 3% or 1/2 CPI ☐ Lesser of 6% or 1/2 CPI Select number of adjustments ☐ 5 ☐ 10
Activities of daily living	☐ No ☐ Yes If Yes, Additional maximum amount ☐ 10% ☐ 20% ☐ 30% ☐ 40%
Business income protection	☐ No ☐ Yes If Yes, ☐ 15% to $2,500 ☐ 25% to $5,000
Special conditions limitation	☐ No ☐ Yes If Yes, ☐ None ☐ 12 months ☐ 24 months
Survivor income benefit	**(2-99)** ☐ 3-month gross lump sum ☐ 6-month gross lump sum **(100+ only)** ☐ No ☐ Yes If yes, ☐ 3-month gross lump sum ☐ 6-month gross lump sum
Infectious & contagious disease	☐ No ☐ Yes If Yes, Waiting period: ☐ 6 months ☐ 12 months Earnings loss: ☐ 20% ☐ 40% Duration of benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ Duration of claim Benefits cease if earnings exceed: ☐ 80 % ☐ 60 %
Accidental dismemberment and loss of sight	☐ No ☐ Yes If Yes, Loss occurs within: ☐ 90 Days ☐ 180 Days ☐ 365 Days
Extended earnings	☐ No ☐ Yes If Yes, Qualification for benefit: ☐ Less than 60% of PDE ☐ Less than 80% of PDE ☐ Less than 100% of PDE Benefit end date: _____ The lesser of ☐ 12 ☐ 24 ☐ 6 ☐ 3 months or when earnings exceed qualification %
Pension contribution	☐ No ☐ Yes
Medical premium supplemental	☐ No ☐ Yes If Yes, Duration of Benefits: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ Duration of claim

[a-g]. WORKPLACE VOLUNTARY BENEFITS (all group sizes)

[**DISABILITY INCOME PLUS**] [☐ No ☐ Yes] [**Plan design**] [☐ Benefits are provided in conjunction with an HSA plan]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[Benefit period (select all that apply)]	[☐ [1-24] Months]	[☐ [1-24] Months]	[☐ [1-3] Years]	[☐ [1-3] Years] [☐ [1-3] Years]
[Elimination period (select all that apply)]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]			

[**Optional Benefits - Employer Selectable**] [☐ Loss of work] [☐ 24-hour coverage] [☐ Takeover]
[☐ Mental, nervous, alcohol and drug abuse] [☐ Portability]
[☐ Sickness elimination period waiver
(available only if 7- or 14-day elimination period is selected for sickness)]

[**Optional Benefits - Employee Selectable**] [☐ COBRA benefit] [☐ Physical Therapy] [☐ ICU/CCU]

[☐ Disability Income Advantage]

[Base Benefit period (select all that apply)]	[☐ [1-24] Months]	[☐ [1-24] Months]	[☐ [1-3] Years]	[☐ [1-3] Years] [☐ [1-3] Years]
[Elimination period (select all that apply)]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]			
[**Optional Riders**]	[☐ 24-hour coverage]	[☐ Hospital confinement]	[☐ Takeover]	
	[☐ COBRA]	[☐ Limited mental health/Emotional disease (only available with EP 0/14, 14/14, or 30/30)]		

[☐ Income Protector (Non-Occ)]

[Elimination period (select all that apply)]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]	[☐ [0-730] / [0-730]]
	[☐ [0-730] / [0-730]]			
[Benefit period (select all that apply)]	[☐ [1-90] Days]	[☐ [1-24] Months]	[☐ [1-2] Years]	[☐ [1-2] Years]
[**Optional Riders**]	[☐ Emergency Accident]	[☐ Outpatient Sickness]	[☐ Hospital Indemnity]	

[**ACCIDENT**] [☐ Group] [☐ Trust] [☐ Individual] [**Base Plan**] [☐ Level 1] [☐ Level 2] [☐ Level 3] [☐ Level 4]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Optional Riders**] (May not be available with all plans.)	[☐ Hospital Intensive Care (per day)]	[☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000]
	[☐ Fracture and dislocation]	[☐ [$1-1,000] ☐ [$1-1,000]
	[☐ Accident total disability (elimination period)]	[☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)] [Month(s)] [Year(s)]
		[☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)] [Month(s)] [Year(s)]
	[☐ On-the-job coverage] [☐ Travel/Lodging]	[☐ Loss of work]]

[**CRITICAL ILLNESS**] [☐ No ☐ Yes] [**Plan design**] [☐ Benefits are provided in conjunction with an HSA plan]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Coverage choices**] [☐ Vascular] [☐ Cancer] [☐ Other critical illnesses [50 or] 100% of face amount]

[**Optional Benefits - Employer Selectable**] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover]

[**Optional Benefits - Employee Selectable**] [☐ Health screening benefit $_____] [☐ Automatic benefit increase]]

[**CRITICAL ILLNESS (Employer paid)**]	[**Plan design**]	[☐ Benefits offered in conjunction with an IRS-qualified pre-tax plan]
[**Coverage choices**]	[☐ Vascular]	[☐ Cancer] [☐ Other group critical illness [50 or] 100% of face amount]
[**Optional Benefits - Employer Selectable**]	[☐ None]	[☐ Benefit recurrence]
	[☐ Takeover	[☐ Health screening:] [☐ $50] [☐ $100] [☐ $150] [☐ [$1-500]
	[☐ Loss of work]	
[**Face amount (employee/member)**]	[☐ Class I Basic: $_____]	[☐ Class I Buy-up/Optional: $_____]
	[☐ Class II Basic: $_____]	[☐ Class II Buy-up/Optional: $_____]
[**Family options**]	[☐ Spouse Basic: $_____ or _____% of employee/member amount]	[☐ Buy-up/Optional: $_____ or _____% of employee/member amount]
	[☐ Child(ren) Basic: $_____ or _____% of employee/member amount]	[☐ Buy-up/Optional: $_____ or _____% of employee/member amount]
[**Maximum benefit amount**]	[☐ Basic: $_____]	[☐ Buy-up/Optional: $_____]

[a-g]. WORKPLACE VOLUNTARY BENEFITS (continued)

[**CRITICAL LIFE**] [☐ No ☐ Yes] [**Plan design**] [☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)][Month(s)][Year(s)]]
[☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)][Month(s)][Year(s)]]
[**Optional Benefits - Employer Selectable**] [☐ Waiver of premium] [☐ Loss of work] [☐ Takeover]
[☐ Additional benefit increase] [☐ Accelerated living benefit - critical illness _____%]
[☐ Accidental death and loss of sight dismemberment]

[**CANCER**] [☐ Cancer Expense] [☐ Group Lump Sum Cancer]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[**Optional Riders - Cancer Expense**] [☐ Hospital indemnity] [☐ Lump sum first diagnosis]
[**Optional Benefits - Group Lump Sum Cancer Employer selectable**] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover benefit]
[**Optional Benefits - Group Lump Sum Cancer Employee selectable**] [☐ Health Screening $_____]
[☐ Automatic benefit increase]

[**WHOLE LIFE**] [☐ Whole Life 65] [☐ Whole Life 90] [☐ Whole Life 99]
[**Optional Riders**] [☐ Waiver of premium] [☐ AD&D] [☐ Loss of work] [☐ Automatic benefit increase] [☐ Family Term]
[☐ Employee Term to Age 65]

[**HEALTH CARE PLUS**] [Hospital Confinement Benefit] [☐ $250] [☐ $500]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[**Optional Riders**] [☐ Hospital Indemnity]

[**SUPPLEMENTAL HEALTH**] [☐ No☐ Yes] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Base plan**]	[☐ Plan A]	[☐ Plan B]	[☐ Plan C]	[☐ Plan D]
[Hospital Indemnity]	[$100/day]	[$200/day]	[$300/day]	[$500/day]
[Hospital First Occurrence]	[$250/day]	[$500/day]	[$500/day (days 1-2)] [$750/day (days 3-4)]	[$500/day (days 1-2)] [$1,000/day (days 3-4)]
[Optional benefits - Employer selectable]				
[☐ Emergency Room]	[$50/day (ER)] [$40/day (urgent care)]	[$100/day (ER)] [$80/day (urgent care)]	[$150/day (ER)] [$120/day (urgent care)]	[$250/day (ER)] [$200/day (urgent care)]
[☐ ICU/CCU/Burn Unit benefit]	[$100/day]	[$200/day]	[$600/day]	[$1,000/day]
[☐ Surgical Schedule]	[$500]	[$1,000]	[$1,000]	[$2,000]
[☐ Diagnostic, laboratory and x-ray]	[$25/test (hospital)] [$20/test (doctor's office or clinic)]	[$25/test (hospital)] [$20/test (doctor's office or clinic)]	[$50/test (hospital)] [$40/test (doctor's office or clinic)]	[$75/test (hospital)] [$60/test (doctor's office or clinic)]
[☐ Outpatient office visit]	[$25]	[$50]	[$75]	[$100]
[☐ Wellness]	[$50]	[$50]	[$100]	[$150]

[If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree, and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, date, year) at _____ (city and state)

By: _____ _____ _____
(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____
(Plan sponsor printed name) (Plan sponsor signature) (Title)

[1-10]. AGENT/BROKER/PRODUCER INFORMATION

1. Agency of Record (for commissions and correspondence)	**2. Agent/Agency of Record (for split commissions)**
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Broker/Producer	**2. Writing Agent/Broker/Producer**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this Employer Group Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent/Broker/Producer's Signature:_____ Date:_____

[2-99] Employer/Group Application - Arkansas

[HUMANA]

FOR GROUP COVERAGE ([2-99] ELIGIBLE EMPLOYEES) Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

[1-10]. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Church or Government entity ☐ Other (explain) _____		Date company established		Federal Tax ID
Nature of business/SIC code	Business phone number ( )		Business fax number ( )	
Do you have more than one location? ☐ No ☐ Yes				
Benefit Administrator/Management contact name:				
Phone number ( )	Fax number ( )	E-mail		
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)				
Billing contact name:				
Billing address (N/A, if same as street address)	City	State	ZIP code	
Phone number ( )	Fax number ( )	E-mail		
[Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]				
[**For Workplace Voluntary Benefits:** Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _]				

[1-10]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	[All	[Medical	[Dental	[Life	[Vision	[STD	[LTD	[Group Critical Illness	[Workplace Voluntary Benefits
A. Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees	]	]	]	]	]	]	]	]	]

As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages, if necessary)

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify)_____
(if you prefer months, please select "Other" and specify the number of months)

Employee effective provision: [(On all plans, except STD and LTD, the employee termination date coincides with the effective date provision. STD/LTD is immediate.)]
[New ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]
[Rehire ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

[1-10]. ELIGIBILITY REQUIREMENTS (continued)

Do you want to exclude a class of employees? ☐ No ☐ Yes
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ other:_____

Employee Eligibility by Class
According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes
If yes, please provide prior group number and termination date:

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan _____
Plan number _____(Assigned by Employer for use in filing IRS form 5500)

Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes

Retiree information
For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age _____ Minimum years of service _____

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered					

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	Total employees

[**Short Term Disability,**] [**Long Term Disability,**] **and** [**Group Critical Illness**] **only**

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	☐	
Increases/decreases requested by employee	☐	
Increases (with Evidence of Insurability) requested by employee	☐	
Decreases due to age	☐	

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee STD	$	$	Basic group critical illness	$	$
Employee LTD	$	$	Buy-up group critical illness		

☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.

[**W-2 Services Option (Please choose one)**
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.]

[1-10]. COBRA/STATE CONTINUATION

Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Number of existing COBRA participants	Medical:	Dental:	Vision:
How many in COBRA election period	Medical:	Dental:	Vision:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes
If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

[1-10]. EMPLOYER CONTRIBUTION(S)

[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes
If yes, indicate amount funded $_____]

[(STD and LTD only) Are employer contributions taxed in employee's paycheck? ☐ No ☐ Yes]

Coverage - Employer's contribution for:	[**Medical**	[**Dental**	[**Vision**	[**Life**	[**Voluntary Life**	[**STD**	[**LTD**	[**Workplace Voluntary Benefits**	[**Spending Account***
Employee	%	%	%	%	%	%	%	%	$
Employee/spouse	%	%	%	%	%	N/A	N/A	%	$
Employee/child	%	%	%	%	%	N/A	N/A	%	$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	%]	$]

[1-10]. PRIOR/CURRENT CARRIER INFORMATION

	[**Medical**	[**Dental**	[**Life**	[**Vision**	[**STD**	[**LTD**
Is this group transferring from another group carrier?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, provide carrier name						
Proposed termination date	]	]	]	]	]	]
[**Dental only:** Did prior dental coverage include orthodontia? ☐ No ☐ Yes]						
[**For Workplace Voluntary Benefits - Existing coverage available to employees** [Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date_____] [CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date_____]]						

[**(For Medical only)** Group's renewal date:

Current carrier rates	Employee $	Spouse $	Child(ren) $	Family $
Plan design		Office visit copay $	Per confinement copay $	
Coinsurance In _____% Out _____%		Deductible In _____% Out_____%	Out-of-pocket In _____% Out _____%	
Emergency room copay $		Prescription drug benefit $		
Renewal rates	Employee $	Spouse $	Child(ren) $	Family $

How many medical carriers have you had in the past five years?]

[1-10]. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder AR-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

[a-i]. MEDICAL PLANS

	Plan 1	**Plan 2**	**Plan 3**
Plan name (as shown in your proposal)			
Office/Specialist copay (if applicable)	$ / $	$ / $	$ / $
Coinsurance	In % / Out %	In % / Out %	In % / Out %
Deductible	In $ / Out $	In $ / Out $	In $ / Out $
Out-of-pocket limit	In $ / Out $	In $ / Out $	In $ / Out $
Prescription drug/Retail card (Level 1 / 2 / 3 / 4)	$ /$ /$ / %	$ /$ /$ / %	$ /$ /$ / %
Prescription drug/Retail card - RxImpact (Group A / B / C / D)	$ /$ /$ /$	$ /$ /$ /$	$ /$ /$ /$
Network name			

[a-i]. MEDICAL PLANS (continued)

Additional riders: Please refer to your proposal for rider availability with plan selected.

	Plan 1	Plan 2	Plan 3
Deductible Carryover Credit	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Supplemental Accident	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
[Employee Assistance Program]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
Other:	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Special State Options: Optional Behavioral Health Benefit	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Workers' Compensation (applicable for Medical plans all group sizes)
Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ☐ No ☐ Yes
If yes, name(s):

[**Health Questionnaire for groups enrolling [2-99] employees:** (check all that apply)

1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? ☐ No ☐ Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
   - confined at home, in a hospital, or in a treatment facility ☐ No ☐ Yes
   - who incurred more than $10,000 of medical expenses in the past 24 months ☐ No ☐ Yes
   - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
4. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	☐ No ☐ Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
• Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	☐ No ☐ Yes
• Cancer or cancerous tumor	☐ No ☐ Yes	• Heart or vascular disease or stroke	☐ No ☐ Yes
• Organ transplant (other than corneal)	☐ No ☐ Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334), if necessary.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment

* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?
☐ No ☐ Yes If yes, please explain:_____

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment?
☐ No ☐ Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.]

[a-i]. DENTAL PLANS (all group sizes)

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In ___% / / Out ___% / /	In ___% / / Out ___% / /
Deductible	In $ Out $	In $ Out $
Annual maximum	$	$
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite fillings for molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____	☐ Child only: lifetime ortho max $ _____ ☐ Adult & child: lifetime ortho max $ _____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
[Oral Surgery Covered in Basic	☐ No ☐ Yes	☐ No ☐ Yes]
Open Enrollment	☐ No ☐ Yes	

[a-i]. LIFE - Please refer to your proposal

Basic Life

Basic Employee Life and AD&D ☐ No ☐ Yes

☐ Flat amount—indicate level: $_____

☐ Salary plan—options are .5x to 7x salary (in .5 increments), rounded to the next highest $1,000. Indicate salary level: _____ x salary
Maximum benefit $_____

☐ Class schedule—no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Choose Flat Amount or Salary Level (Must match for all classes)
1.		
2.		
3.		
4.		

Rate Guarantee ☐ 2 Year ☐ 3 Year

Age Reduction (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____

Basic and Voluntary Age Reduction schedules must match.

Basic Dependent Life ☐ No ☐ Yes

If yes, indicate volume amount

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $1,000, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $2,500, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $5,000; Dependent Age 6 Months to 26 Years $1,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $20,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months, $500, Birth through 14 days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $5,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

☐ Spouse $10,000; Dependent Age 6 Months to 26 Years $10,000, Dependent Age 15 Days to 6 Months $500, Birth through 14 Days No Benefit

[a-i]. LIFE (continued)

[**Voluntary Life**

Voluntary Employee Life ☐ No ☐ Yes

If yes, do you want to select AD&D? ☐ No ☐ Yes

Flat amount—indicate level: $_____

☐ Minimum amount $_____

☐ Maximum benefit $_____

Voluntary Dependent Life ☐ No ☐ Yes

(Only available if Employee Voluntary Life is chosen)

Dependent Child Voluntary Amount ☐ $5,000 ☐ $10,000

[**Rate Guarantee** ☐ 2 Year ☐ 3 Year]

[**Age Reduction** (Refer to your proposal) Schedule 1 _____ Schedule 2 _____ Schedule 3 _____]

Basic and Voluntary Age Reduction schedules must match.

[Portability of coverage (Applicable to Voluntary Life only) Groups [2-99]: Included (Unless mandated by state)]]

[a-i]. VISION PLANS (all group sizes)

Plan name (as shown on your proposal)

[a-i]. SHORT TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder GN-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	☐ 60% ☐ Flat amount $ _____	☐ 60% ☐ Flat amount $ _____
Weekly benefit minimum	$25.00	$25.00
Weekly benefit maximum	$	$
Earnings definition	■ Base Salary	■ Base Salary
Duration weeks	☐ 13 ☐ 26	☐ 13 ☐ 26
Elimination period (accident/ sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30
Pre-existing limitation	■ 3/12	■ 3/12
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	■ 2 Years	■ 2 Years

[a-i]. LONG TERM DISABILITY (group sizes 2-9). Attach additional signed and dated sheets (reorder GN-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	☐ Contributory ☐ Non-contributory	☐ Contributory ☐ Non-contributory
Benefit schedule (select one)	■ 60%	■ 60%
Monthly benefit minimum	■ Greater of $100 or 10% of monthly income loss	■ Greater of $100 or 10% of monthly income loss
Monthly benefit maximum	$	$
Duration	☐ 5 Years ☐ SSNRA	☐ 5 Years ☐ SSNRA
Elimination period	Days: ☐ 90 ☐ 180	Days: ☐ 90 ☐ 180
Definition of disability	Year own occupation: ■ 2	Year own occupation: ■ 2
Pre-existing limitation	■ 12/24	■ 12/24
Mental health and substance abuse limitation	■ 24-month outpatient	■ 24-month outpatient
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	■ 2 Years	■ 2 Years
Survivor income benefit	■ 3 month gross lump sum	■ 3 month gross lump sum

[a-i]. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____ ☐ Flat amount $ _____
Weekly benefit minimum	$25.00
Weekly benefit maximum	$
Earnings definition	■ Base Salary
Duration weeks	☐ 13 ☐ 26 ☐ 52 ☐ Other _____
Elimination period (Accident/Sickness)	☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ Other _____
Pre-existing limitation	☐ None ☐ 3/12 ☐ 6/12 ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

[a-i]. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336) if necessary.

Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

[a-i]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	☐ 50% ☐ 60% ☐ 66.67% ☐ Other _____
Monthly benefit minimum	■ Greater of $100 or 10% of Monthly Income Loss
Monthly benefit maximum	$
Earnings definition	■ Base Salary
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other _____
Elimination period	Days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ Other _____
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other _____
Pre-existing limitation	☐ 3/3/12 ☐ 6/6/12 ☐ 12/12/24 ☐ 3/6/12 ☐ 6/6/24 ☐ Other _____
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other _____
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Waiting period: Rehired/New employees	☐ Eligible on date of employment ☐ Eligible after active employment for _____ days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other _____

Additional benefits: Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ■ lesser of 3% or 1/2 CPI, select number of adjustments ☐ 5 ☐ 10
Activities of daily living	☐ No ☐ Yes If Yes, select additional maximum amount ☐ 10% ☐ 20% ☐ 30% ☐ 40%
Business income protection	☐ No ☐ Yes If Yes, ■ 25% to $5,000
Special conditions limitiation	☐ No ☐ Yes If Yes, ■ 24 months
Survivor income benefit	☐ 3-month gross lump sum ☐ 6-month gross lump sum

[a-i]. WORKPLACE VOLUNTARY BENEFITS (all group sizes)

[**DISABILITY INCOME PLUS**] [☐ No ☐ Yes] [**Plan design**] [☐ Benefits are provided in conjunction with an HSA plan]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[Benefit period (select all that apply)] [☐ [1-24] Months] [☐ [1-24] Months] [☐ [1-3] Years] [☐ [1-3] Years] [☐ [1-3] Years]
[Elimination period (select all that apply)] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]]

[**Optional Benefits - Employer Selectable**] [☐ Loss of work] [☐ 24-hour coverage] [☐ Takeover]
[☐ Mental, nervous, alcohol and drug abuse] [☐ Portability]
[☐ Sickness elimination period waiver
(available only if 7- or 14-day elimination period is selected for sickness)]

[**Optional Benefits - Employee Selectable**] [☐ COBRA benefit] [☐ Physical Therapy] [☐ ICU/CCU]

[☐ Disability Income Advantage]
[Base Benefit period (select all that apply)] [☐ [1-24] Months] [☐ [1-24] Months] [☐ [1-3] Years] [☐ [1-3] Years] [☐ [1-3] Years]
[Elimination period (select all that apply)] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]]
[**Optional Riders**] [☐ 24-hour coverage] [☐ Hospital confinement] [☐ Takeover]
[☐ COBRA] [☐ Limited mental health/Emotional disease
(only available with EP 0/14, 14/14, or 30/30)]

[☐ Income Protector (Non-Occ)]
[Elimination period (select all that apply)] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]] [☐ [0-730] / [0-730]]
[☐ [0-730] / [0-730]]
[Benefit period (select all that apply)] [☐ [1-90] Days] [☐ [1-24] Months] [☐ [1-2] Years] [☐ [1-2] Years]
[**Optional Riders**] [☐ Emergency Accident] [☐ Outpatient Sickness] [☐ Hospital Indemnity]

[a-i]. WORKPLACE VOLUNTARY BENEFITS (continued)

[**ACCIDENT**] [☐ Group] [☐ Trust] [☐ Individual] [**Base Plan**] [☐ Level 1] [☐ Level 2] [☐ Level 3] [☐ Level 4]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Optional Riders**] (May not be available with all plans.)
[☐ Hospital Intensive Care (per day)] [☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000] ☐ [$1-1,000]
[☐ Fracture and dislocation] [☐ [$1-1,000] ☐ [$1-1,000]
[☐ Accident total disability (elimination period)] [☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)] [Month(s)] [Year(s)]
[☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)] [Month(s)] [Year(s)]
[☐ On-the-job coverage] [☐ Travel/Lodging] [☐ Loss of work]]

[**CRITICAL ILLNESS**] [☐ No ☐ Yes] [**Plan design**] [☐ Benefits are provided in conjunction with an HSA plan]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Coverage choices**] [☐ Vascular] [☐ Cancer] [☐ Other critical illnesses [50 or] 100% of face amount]

[**Optional Benefits - Employer Selectable**] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover]

[**Optional Benefits - Employee Selectable**] [☐ Health screening benefit $_____] [☐ Automatic benefit increase]]

[**CRITICAL LIFE**] [☐ No ☐ Yes] [**Plan design**] [☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)][Month(s)][Year(s)]]
[☐ [1-45] [Day(s)][Month(s)][Year(s)]] [☐ [1-45] [Day(s)][Month(s)][Year(s)]]
[**Optional Benefits - Employer Selectable**] [☐ Waiver of premium] [☐ Loss of work] [☐ Takeover]
[☐ Additional benefit increase] [☐ Accelerated living benefit - critical illness ____%]
[☐ Accidental death and loss of sight dismemberment]

[**CANCER**] [☐ Cancer Expense] [☐ Group Lump Sum Cancer]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[**Optional Riders - Cancer Expense**] [☐ Hospital indemnity] [☐ Lump sum first diagnosis]
[**Optional Benefits - Group Lump Sum Cancer Employer selectable**] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover benefit]
[**Optional Benefits - Group Lump Sum Cancer Employee selectable**] [☐ Health Screening $_____]
[☐ Automatic benefit increase]

[**WHOLE LIFE**] [☐ Whole Life 65] [☐ Whole Life 90] [☐ Whole Life 99]
[**Optional Riders**] [☐ Waiver of premium] [☐ AD&D] [☐ Loss of work] [☐ Automatic benefit increase] [☐ Family Term]
[☐ Employee Term to Age 65]

[**HEALTH CARE PLUS**] [Hospital Confinement Benefit] [☐ $250] [☐ $500]
[☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[**Optional Riders**] [☐ Hospital Indemnity]

[**SUPPLEMENTAL HEALTH**] [☐ No☐ Yes] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[**Base plan**]	[☐ Plan A]	[☐ Plan B]	[☐ Plan C]	[☐ Plan D]
[Hospital Indemnity]	[$100/day]	[$200/day]	[$300/day]	[$500/day]
[Hospital First Occurrence]	[$250/day]	[$500/day]	[$500/day (days 1-2)] [$750/day (days 3-4)]	[$500/day (days 1-2)] [$1,000/day (days 3-4)]
[**Optional benefits - Employer selectable**]				
[☐ Emergency Room]	[$50/day (ER)] [$40/day (urgent care)]	[$100/day (ER)] [$80/day (urgent care)]	[$150/day (ER)] [$120/day (urgent care)]	[$250/day (ER)] [$200/day (urgent care)]
[☐ ICU/CCU/Burn Unit benefit]	[$100/day]	[$200/day]	[$600/day]	[$1,000/day]
[☐ Surgical Schedule]	[$500]	[$1,000]	[$1,000]	[$2,000]
[☐ Diagnostic, laboratory and x-ray]	[$25/test (hospital)] [$20/test (doctor's office or clinic)]	[$25/test (hospital)] [$20/test (doctor's office or clinic)]	[$50/test (hospital)] [$40/test (doctor's office or clinic)]	[$75/test (hospital)] [$60/test (doctor's office or clinic)]
[☐ Outpatient office visit]	[$25]	[$50]	[$75]	[$100]
[☐ Wellness]	[$50]	[$50]	[$100]	[$150]

[If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, date, year) at _____ (city and state)

By: _____ _____ _____

(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____

(Plan sponsor printed name) (Plan sponsor signature) (Title)

[1-10]. AGENT/BROKER/PRODUCER INFORMATION

1. Agency of Record (for commissions and correspondence)	2. Agent/Agency of Record (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Broker/Producer	**2. Writing Agent/Broker/Producer**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this Employer Group Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent/Broker/Producer's Signature:_____ Date:_____

Group Employee and Individual Application and Enrollment Form - [[2-99] Employees] [Arkansas]

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

Please print clearly and fill in each applicable circle.

Proposed effective date: _ _ / _ _ / _ _ _ _

Employer / Group name	Employer / Group city	State

Qualifying Event Instructions Date of Qualifying Event: _ _ / _ _ / _ _ _ _

[❍ New business enrollment] [❍ Open Enrollment event] [❍ Dependent birth or adoption] [❍ Loss of coverage]
[❍ New hire / Newly eligible] [❍ Rehire / Reinstatement] [❍ Marital status change] [❍ Other_____]

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason and SSN within the field below.
Employee / Individual		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN: N/A (complete in Employee / Individual Information section.)
Spouse / Domestic Partner		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child / Dependent		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child / Dependent		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child / Dependent		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:

[Within the past [1-12] months have you or, if applicable, your spouse, applying for coverage used any tobacco product?] [❍ N ❍ Y]
[If yes, please indicate whether this answer applies to you (employee / individual) or your spouse] [❍ Employee / Individual] [❍ Spouse]

Employee / Individual Information

[Hours worked per week:] **[Date of full time hire: _ _ / _ _ / _ _ _ _]**

SSN	Street address	APT / Suite / Box

City	State	ZIP code	Phone # ( )

Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation

Employment status (check one) ❍ Active ❍ Retiree ❍ COBRA	Annual salary $

Prior / Existing Coverage: IMPORTANT - DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Medical

[1-3]. [Prior medical coverage during the past [1-18] months (individual or other group coverage)? ❍ N ❍ Y]

[Prior medical insurance carrier name]	[Policy #]	**[Prior coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]	[Effective date _ _ / _ _ / _ _ _ _] [Term date _ _ / _ _ / _ _ _ _]

[1-3]. [Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y]

[Other medical insurance carrier name]	[Policy #]	**[Other coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]	[Effective date _ _ / _ _ / _ _ _ _] [Term date _ _ / _ _ / _ _ _ _]

[1-3]. [Medicare]

[Employee / Individual coverage: ❍ N ❍ Y]	[Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _]
[Spouse coverage: ❍ N ❍ Y]	[Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _]

Last name: | First name:

Dental

[1-2]. [Prior dental coverage during the past [1-12] months (individual or other group coverage)? ❍ N ❍ Y]

[1-2]. [Prior orthodontia coverage in the past [1-12] months? ❍ N ❍ Y]

[Prior dental insurance carrier name]	Policy #	**[Prior coverage type:]** ❍ [Employee / Individual only] ❍ [Employee / Individual and spouse] ❍ [Employee / Individual and child(ren)] ❍ [Family]
	Effective date _ _ / _ _ / _ _ _ _]	
[Prior carrier phone # ( )]	Term date _ _ / _ _ / _ _ _ _]	

Coverage Options

Medical

Group #: | Benefit #: | Class/Div:

[Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family] [❍ No Coverage (complete waiver)]

[Plan name:]

Health Savings Account

Group #: | Benefit #: | Class/Div:

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

[Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)]

[Beneficiary for this account will be the employee / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.]

Dental

Group #: | Benefit #: | Class/Div:

[Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family] [❍ No Coverage (complete waiver)]

[Plan name:]

Basic Life [/ AD&D]

Group #: | Benefit #: | Class/Div:

[Basic dependent life ❍ N ❍ Y (If no, complete waiver.)]

[Class (employer will provide you with this information, if needed)]

Voluntary Life [/ AD&D]

Group #: | Benefit #: | Class/Div:

[Voluntary employee / individual life coverage ❍ N ❍ Y]

[Amount (min [$1-unlimited]) $]

[Voluntary spouse life coverage? ❍ N ❍ Y]

[Amount (min $1-unlimited) $]

[Voluntary child(ren) life coverage? ❍ N ❍ Y]

Vision

Group #: | Benefit #: | Class/Div:

[Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family] [❍ No Coverage (complete waiver)]

[Plan name:]

Short Term Disability

Group #: | Benefit #: | Class: | Div:

[Short Term Disability ❍ N ❍ Y (If no, complete waiver.)] [Buy-up percent/amount _____]

Long Term Disability

Group #: | Benefit #: | Class: | Div:

[Long Term Disability ❍ N ❍ Y (If no, complete waiver.)] [Buy-up percent/amount _____]

Last name: | First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident Group #: | Benefit #: | Class: | Div:

[❍ Accident] [❍ N ❍ Y] [Benefit Level:] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]

[Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]

[❍ Optional Hospital Intensive Care Unit Benefits Rider]
[❍ $1-50,000][per day] [per month] [per year]
[❍ $1-50,000][per day] [per month] [per year]
[❍ $1-50,000][per day] [per month] [per year]
[❍ $1-50,000][per day] [per month] [per year]

[❍ Optional Fracture and Dislocation Benefits Rider]
[❍ $1-50,000] [❍ $1-50,000]

[❍ Optional Accident Total Disability Benefits Rider: **Elimination Period:**] [❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[Elimination Benefit:] [❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000]
[❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000]

Accident - 2012 Group #: | Benefit #: | Class: | Div:

[❍ Accident] [❍ N ❍ Y] [Benefit Level:] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]

[Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]

[❍ Pet Lodging] [❍ $1-1,000][per day] [per month] [per year] [❍ $1-1,000][per day] [per month] [per year]
[❍ $1-1,000][per day] [per month] [per year] [❍ $1-1,000][per day] [per month] [per year]

Disability Income Plus Group #: | Benefit #: | Class: | Div:

[❍ Disability Income Covering Accident and Sickness] [❍ N ❍ Y]
[Base Benefit Period:] [❍ 1-120][Month][Days][Year][❍ 1-120][Days][Year][❍ 1-120] [Month][Days][Year]
[❍ 1-120][Month][Days][Year][❍ 1-120][Month][Days][Year]
[Base Elimination Period:] [❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]]

[Monthly Benefit $]

[❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period] [❍ N ❍ Y]
[Base Benefit Period:] [❍ 1-120][Month][Days][Year][❍ 1-120][Days][Year][❍ 1-120] [Month][Days][Year]
[❍ 1-120][Month][Days][Year][❍ 1-120][Month][Days][Year]
[Base Elimination Period:] [❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]

[**Optional Disability Income Benefits:**] [❍ ICU / CCU Benefit] [❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000]
[❍ Physical Therapy Benefit] [❍ COBRA Rider] [COBRA Monthly Benefit $]

Disability Income Advantage Group #: | Benefit #: | Class: | Div:

[❍ Disability Income Advantage] [❍ N ❍ Y]
[Base Benefit Period:] [❍ 1-120][Month][Days][Year][❍ 1-120][Days][Year][❍ 1-120] [Month][Days][Year]
[❍ 1-120][Month][Days][Year][❍ 1-120][Month][Days][Year]
[Base Elimination Period:] [❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]][❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]]

[Monthly Benefit $]

[Optional Riders:] [❍ Hospital Confinement] [❍ COBRA Rider] [COBRA Monthly Benefit $]

Whole Life [/ AD&D] Group #: | Benefit #: | Class: | Div:

[❍ Whole Life] [/ AD&D] [❍ N ❍ Y] [❍ Whole Life 99] [❍ Whole Life 90] [❍ Whole Life 65] [Employee / Individual Benefit $]

[❍ AD&D Rider] [❍ Automatic Premium Loan Option]

[❍ Automatic Benefit Increase Rider]
[❍ $1-120 /] [Days][Week][Month] [Year]
[❍ $1-120 /] [Days][Week][Month] [Year]

[❍ Employee / Individual Term Rider to 65
Employee / Individual Benefit $]

[❍ Family Term Rider
Spouse Benefit $] [Child(ren) Benefit $]

Whole Life Spouse [/ AD&D] Group #: | Benefit #: | Class: | Div:

[❍ Stand Alone Spouse] [/ AD&D] [❍ N ❍ Y] [❍ Whole Life 99] [❍ Whole Life 90] [❍ Whole Life 65] [Spouse Benefit $]

[❍ AD&D Rider] [❍ Family Term Rider (Child Coverage Only)
Child(ren) Benefit Amount $] [❍ Automatic Premium Loan Option]

Last name:	First name:

Whole Life Child(ren) [/ AD&D] Group #:		Benefit #:		Class:		Div:	
[❍ Whole Life Child(ren)] [/ AD&D] [❍ N ❍ Y]							
[**Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.]**							
[❍ N ❍ Y **Coverage on Child 1**	Child 1 Name					Child 1 Benefit $]	
[❍ N ❍ Y **Coverage on Child 2**	Child 2 Name					Child 2 Benefit $]	
[❍ N ❍ Y **Coverage on Child 3**	Child 3 Name					Child 3 Benefit $]	

Level Term Life Group #:		Benefit #:		Class:		Div:	
[❍ Level Term Life] [/ AD&D] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Spouse] [❍ Child(ren)]				**[Base Plan:]** [❍10-Year Term] [❍20-Year Term] **[Optional Benefit:]** [❍ Automatic Benefit Increase]	
[Employee / Individual Benefit $]		[Spouse Benefit $]				[Child(ren) Benefit $]	

[If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100] ? ❍ N ❍ Y]
[If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
[❍ You (Employee / Individual)] [❍ Spouse] [❍ Dependent] [Name_____]]

Term to 95 Group #:		Benefit #:		Class:		Div:	
[❍ Term to 95] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Spouse] [❍ Children]					
[Employee / Individual Benefit $]		[Stand alone Spouse Benefit $]				[Stand alone Child(ren) Benefit $]	

Critical Illness Group #:		Benefit #:		Class:		Div:	
[❍ Critical Illness] [❍ N ❍ Y] [❍ Critical Illness and Cancer] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]					
[Optional Benefits:] [❍ Automatic Benefit Increase] [❍ Health Screening] [❍ Return on Premium]						[Employee / Individual Benefit $]	

[Have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]? ❍ N ❍ Y] [If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. [❍ You (Employee / Individual)] [❍ Spouse] [❍ Dependent] [Name_____]]

Group Lump Sum Cancer Group #:		Benefit #:		Class:		Div:	
[❍ Group Lump Sum Cancer] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]					

[Have you or any dependent had a parent, brother, or sister with a history of cancer diagnosis prior to age [1-100] ? ❍ N ❍ Y]
[If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
[❍ You (Employee / Individual)] [❍ Spouse] [❍ Dependent] [Name_____]]

[Rider:] [❍ Automatic Benefit Increase] [❍ Health Screenings]	[Base Benefit $]

Cancer Expense Group #:		Benefit #:		Class:		Div:	
[❍ Cancer Expense] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]					
[❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount)]		**[Rider:]** [❍ Hospital Indemnity Rider]				[Base Benefit $]	

Supplemental Health Group #:		Benefit #:		Class:		Div:	
[❍ Supplemental Health] [❍ N ❍ Y]		**[Coverage type:]** [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]					
[Plan type:] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]							

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits	
Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Last name:	First name:

Evidence of Health Status

This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [medical,][disability,] [life,] [or] [workplace voluntary] benefit coverage.]

[This section is required to be filled out for [Group Term Life,] [Long Term Disability,] [and] [Short Term Disability], if the following criteria applies:]

[1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]

[1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]

[1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]

[1-7.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?		❍ N ❍ Y]
[1-7.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, [back problems,] strained/sprained/fractured/broken limb or as a result of pregnancy?		❍ N ❍ Y]
[1-7.] [Have you or any dependent been diagnosed or received treatment for [an immune system disorder (i.e. Lupus, ITP),]AIDS or an AIDS-related complex?	❍ N ❍ Y]	

[1-7.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]

[a-o.]	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90)]?	❍ N ❍ Y]	[a-o.]	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y]
[a-o.]	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y]	[a-o.]	Stomach, gall bladder, digestive, intestinal, or colon disorders?	❍ N ❍ Y]
[a-o.]	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y]	[a-o.]	Rheumatoid arthritis[; [or] back disorders; or joint disorders]?	❍ N ❍ Y]
[a-o.]	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y]	[a-o.]	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y]
[a-o.]	End stage renal disease; disease of kidney?	❍ N ❍ Y]	[a-o.]	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y]
[a-o.]	Kidney stones; bladder?	❍ N ❍ Y]	[a-o.]	Diseases of the eye, ear, nose, or throat?	❍ N ❍ Y]
[a-o.]	Male or female organs; or infertility?	❍ N ❍ Y]	[a-o.]	Alcoholism or drug habit?	❍ N ❍ Y]
[a-o.]	Cancer, and/or cancerous tumor[; including skin cancer]?	❍ N ❍ Y]			

[1-7.] [Has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	❍ N ❍ Y]
[1-7.] [Within the past [1-5] years, has anyone enrolling or applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y]
[1-7.] [Are you or any dependent to be covered currently pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date:_____]	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets, (reorder AR-51340-MH), if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _]

Last name:	First name:

Medical Health History

This information should not be submitted more than 60 days prior to the effective date. [Complete this section for individuals, including dependents, enrolling for medical, disability, life, or workplace voluntary benefit coverage.]

[1-6.] [Are you or any dependents to be covered currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	❍ N ❍ Y]
[1-6.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu [, back problems], strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y]
[1-6.] [Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y]
[1-6.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y]
[1-6.] [During the last [1-24] months, have you or any dependents to be covered been diagnosed with, or treated for, any illness or injury or had surgery or hospitalization recommended?	❍ N ❍ Y]
[1-6.] [Within the past [1-12] months, have you or any dependents to be covered incurred medical expenses in excess of [$1-100,000]?	❍ N ❍ Y]

If selecting life, please complete the following questions:

[1-4.] [In the past 5 years has any Proposed Insured been diagnosed, sought treatment, taken medication, or been hospitalized for any of the following: heart attack/heart surgery/heart disease, blood pressure readings above the normal range which have not been controlled with medication, stroke/transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, diabetes (insulin dependent), alcohol and/or drug abuse, emphysema/lung disease, liver disease/ hepatitis/cirrhosis, neurological disorder/multiple sclerosis, lupus, blood disorder, or epilepsy?	❍ N ❍ Y]
[1-4.] [Had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?	❍ N ❍ Y]
[1-4.] [Has any child proposed for coverage ever been diagnosed with or treated for congenital cardiac abnormality or other abnormalities, spina bifida, down's syndrome, cerebral palsy, or cystic fibrosis?	❍ N ❍ Y]
[1-4.] [Has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder AR-51340-MH), if necessary.]

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Last name: First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):				I decline to apply for group coverage because of:
[Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	[❍ Spousal coverage]
[Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	[❍ Medicare supplement]
[Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	[❍ Individual coverage]
[Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	[❍ Coverage under another carrier's plan provided by my employer / group]
[Short Term Disability for:	❍ Myself]			[❍ Other: _____]
[Long Term Disability for:	❍ Myself]			
[Health Savings Account for:	❍ Myself]			
Waive Coverage for Workplace Voluntary Benefits:				
[Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Term to 95 for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]	
[Disability Income Plus for:	❍ Myself]			
[Disability Income Advantage for:	❍ Myself]			

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period, if such misrepresentation materially affected the acceptance of the risk.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Last name: | First name:

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ County _____ State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Last name: First name:

Large Group Employee and Individual Application and Enrollment Form

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee and Individual Application and Enrollment Form as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

Qualifying Event Instructions **Office use only**

[❍ New business enrollment] [❍ Open Enrollment event] [❍ Marital status change] [❍ Other_____]

[❍ New hire/Newly eligible] [❍ Rehire/Reinstatement] Qualifying event date (MM/DD/YYYY) / / Benefit effective date (MM/DD/YYYY) / /

[❍ Dependent birth or adoption] [❍ Loss of coverage]

Employee / Individual information

Last name First name MI

Social security number - - Date of birth (MM/DD/YYYY) / / Area code ( ) Phone number -

Height (ft / in) / Weight (lbs)

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male Language of choice ❍ English ❍ Spanish

City State Zip code County / Parish

E-mail address

Employment status ❍ Full-time employee / individual ❍ Retiree ❍ COBRA Date of full-time hire (MM/DD/YYYY) / /

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason:_____

Annual Salary

$

Hours Worked per Week

Occupation

HMO/POSonly Primary care physician name Primary care physician ID # Current patient? ❍ Yes ❍ No

HMO/POSonly OBGYN Primary care physician name (if applicable) Primary care physician ID # Current patient? ❍ Yes ❍ No

Last name: First name:

Dependent information

Enter information for each covered dependent, including spouse.

1

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Height (ft / in) / | Weight (lbs)

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

2

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Height (ft / in) / | Weight (lbs)

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

3

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Height (ft / in) / | Weight (lbs)

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

4

Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number - - | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Height (ft / in) / | Weight (lbs)

Dependent status (if applicable): ❍ Full-time student ❍ Disabled
If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only: Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only: OBGYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Last name: | First name:

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

[Coverage type:][❍ Employee / Individual only]
[❍ Employee / Individual & spouse]
[❍ Employee / Individual & child(ren)]
[❍ Family]
[❍ Other]

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

[• Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No] [If yes, list all: (This section must be completed for Humana to process any medical claims.)]]

[Medicare ID or medical carrier name:]
[Starting date (MM/DD/YYYY) / /]
[End date, if applicable (MM/DD/YYYY) / /]
[Coverage Type (check all that apply)]
[❍ Employee / Individual]
[❍ Spouse]
[❍ Child(ren)]

[Medicare ID or medical carrier name:]
[Starting date (MM/DD/YYYY) / /]
[End date, if applicable (MM/DD/YYYY) / /]
[Coverage Type (check all that apply)]
[❍ Employee / Individual]
[❍ Spouse]
[❍ Child(ren)]

[• Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past [1-18] months? ❍ Yes ❍ No] [If yes, list all: (This section must be completed for Humana to process any medical claims)]]

[Prior medical carrier name:]
[Starting date (MM/DD/YYYY) / /]
[End date, if applicable (MM/DD/YYYY) / /]
[Coverage Type (check all that apply)]
[❍ Employee / Individual]
[❍ Spouse]
[❍ Child(ren)]

[Prior medical carrier name:]
[Starting date (MM/DD/YYYY) / /]
[End date, if applicable (MM/DD/YYYY) / /]
[Coverage Type (check all that apply)]
[❍ Employee / Individual]
[❍ Spouse]
[❍ Child(ren)]

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Office use only
Group # | Benefit # | Class/Div #

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name: First name:

Flexible Spending Account (FSA)

Do you elect the flexible health account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA HC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Do you elect the flexible dependent care account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Dental

Office use only Group # Benefit # Class/Div #

[Coverage Type] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family] [❍ Other]

Plan name

[• Within the past [1-12] months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ❍ Yes ❍ No] [If yes, list all: (This section must be completed for Humana to process any dental claims)]]

[Current dental carrier name:] [Orthodontia coverage? ❍ Yes ❍ No] [Starting date (MM/DD/YYYY) / /] [End date, if applicable (MM/DD/YYYY) / /]

[Coverage Type (check all that apply)] [❍ Employee / Individual] [❍ Spouse] [❍ Child(ren)]

[Prior dental carrier name:] [Orthodontia coverage? ❍ Yes ❍ No] [Starting date (MM/DD/YYYY) / /] [End date, if applicable (MM/DD/YYYY) / /]

[Coverage Type (check all that apply)] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]

[Employee Primary care dentist name [Dentist ID #] [Current patient? ❍ Yes ❍ No]
[HMO/POS only]

[Employee Primary care dentist name] [Dentist ID #] [Current patient?
[**1** DHMO: ❍ Yes ❍ No]
[**2** DHMO: ❍ Yes ❍ No]
[**3** DHMO: ❍ Yes ❍ No]

Basic Life [/ AD&D]

Office use only Group # Benefit # Class/Div #

[Do you elect basic employee / individual life coverage? ❍ Yes ❍ No If no, complete waiver section]

[Class (employer / group will provide you with this information if needed)]

[Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section]

Last name: First name:

Voluntary Life [/ AD&D]

Office use only Group # Benefit # Class/Div #

[Do you elect voluntary employee / individual life coverage?

❍ Yes ❍ No [If no, complete waiver section]]

[If yes, amount elected (minimum of [$1-Unlimited]): $, .00]

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

[Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section]

[If yes, voluntary spouse life coverage (minimum of [$1-Unlimited]): $, .00]

[Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section]

Vision

Office use only Group # Benefit # Class/Div #

[Covered individual] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family] [❍ Other]

Plan name

Short Term Disability

[Do you elect short term disability coverage?

❍ Yes ❍ No If no, complete waiver section]

[Buy-up percent/amount _____]

Office use only
Group # Benefit # Class # Div #

Long Term Disability

[Do you elect long term disability coverage?

❍ Yes ❍ No If no, complete waiver section]

Buy-up percent/amount _____]

Office use only
Group # Benefit # Class # Div #

Group Term Life [/ AD&D]

Office use only Group# Benefit# Class# Div#

Coverage requested for (check all that apply)		Coverage requested (complete only if plan provides a choice of benefit schedules)	Cost per pay period
[Employee / Individual]	[❍ Basic Term Life		$, .00]
	[❍ Supplemental Term Life*		$, .00]
	[❍ Basic AD&D		$, .00]
	[❍ Supplemental AD&D		$, .00]
[Spouse]	[❍ Basic Term Life		$, .00]
	[❍ Supplemental Term Life*		$, .00]
	[❍ Basic AD&D		$, .00]
	[❍ Supplemental AD&D		$, .00]
[Child(ren)]	[❍ Basic Term Life		$, .00]
	[❍ Supplemental Term Life*		$, .00]
	[❍ Basic AD&D		$, .00]
	[❍ Supplemental AD&D		$, .00]

*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Last name: First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident

Office use only Group # Benefit # Class # Div #

[❍ Accident] [❍ N ❍ Y] [**Benefit Level:**] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]

Coverage type:] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]

[❍ Optional Hospital Intensive Care Unit Benefits Rider] [❍ $1-50,000] [per day][per month][per year]
[❍ $1-50,000] [per day][per month][per year]
[❍ $1-50,000] [per day][per month][per year]
[❍ $1-50,000] [per day][per month][per year]

[❍ Optional Fracture and Dislocation Benefits Rider] [❍ $1-50,000] [❍ $1-50,000]

[❍ Optional Accident Total Disability Benefits Rider: Elimination Period] [❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[Elimination Benefit] [❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000]
[❍ $1-50,000] [❍ $1-50,000] [❍ $1-50,000]

Accident - 2012

Office use only Group # Benefit # Class # Div #

[❍ Accident] [❍ N ❍ Y] [**Benefit Level:**] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]

[**Coverage type:**] [❍ Employee / Individual only] [❍ Employee / Individual and spouse] [❍ Employee / Individual and child(ren)] [❍ Family]

[❍ Pet Lodging [❍ $1-1,000][per day][per month][per year] [❍ $1-1,000][per day][per month][per year]
[❍ $1-1,000][per day][per month][per year] [❍ $1-1,000][per day][per month][per year]

Disability Income Plus

Office use only Group # Benefit # Class # Div #

[❍ Disability Income Covering Accident and Sickness][❍ N ❍ Y]
[**Base Benefit Period:**] [❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[**Base Elimination Period:**] [❍ 0-500][/ 0-500][❍ 0-500][/ 0-500][❍ 0-500][/ 0-500][❍ 0-500][/ 0-500]
[❍ 0-500][/ 0-500][❍ 0-500][/ 0-500][❍ 0-500][/ 0-500][❍ 0-500][/ 0-500][❍ 0-500][/ 0-500]]

[❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period] [❍ N ❍ Y]
[**Base Benefit Period:**] [❍ 1-120] [Month][Days][Year][❍ 1-120][Days][Year]
[❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year]
[**Base Elimination Period:**] [❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]

[Monthly Benefit $, .00]

[COBRA Monthly Benefit $, .00]

[**Optional Disability Income Benefits:** [❍ ICU/CCU Benefit] [❍ $1-2,000]
[❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000] [❍ $1-2,000]
[❍ Physical Therapy Benefit]
[❍ COBRA Rider]

Last name: First name:

Disability Income Advantage

Office use only Group # Benefit # Class # Div #

[❍ Disability Income Advantage] [❍ N ❍ Y]

[**Base Benefit Period:**] [❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year] [❍ 1-120] [Month][Days][Year]
[❍ 1-120] [Month][Days][Year]

[Monthly Benefit $, .00]

[**Base Elimination Period:**] [❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]
[❍ 0-500][/ 0-500]]❍ 0-500][/ 0-500]]

[COBRA Monthly Benefit $, .00]

[Optional Riders:] [❍ Hospital Confinement] [❍ COBRA Rider]

Whole Life [/ AD&D]

Office use only Group # Benefit # Class # Div #

[❍ Whole Life] [/ AD&D] [❍ N ❍ Y] [❍ Whole Life 99] [❍ Whole Life 90] [❍ Whole Life 65]

[Employee / Individual Benefit $, .00]

[❍ AD&D Rider] [❍ Automatic Premium Loan Option]

[❍ Automatic Benefit Increase Rider]
[❍ $1-120 /] [Days][Week][Month][Year]
[❍ $1-120 /] [Days][Week][Month][Year]

[❍ Employee Term Rider to 65
Employee / Individual Benefit
$_____]

[❍ Family Term Rider
Spouse Benefit $ _____
Child(ren) Benefit $ _____]

Whole Life Spouse [/ AD&D]

Office use only Group # Benefit # Class # Div #

[❍ Whole Life Spouse] [/ AD&D] [❍ N ❍ Y] [❍ Whole Life 99] [❍ Whole Life 90] [❍ Whole Life 65]

[Spouse Benefit $, .00]

[❍ AD&D Rider] [❍ Automatic Premium Loan Option]
[❍ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount $_____]

Whole Life Child(ren) [/ AD&D]

Office use only Group # Benefit # Class # Div #

[❍ Whole Life Child(ren)] [/ AD&D] [❍ N ❍ Y]

Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.]

[❍ N ❍ Y **Coverage on Child 1** Child 1 Name_____ Child 1 Benefit $ _____]
[❍ N ❍ Y **Coverage on Child 2** Child 2 Name_____ Child 2 Benefit $ _____]
[❍ N ❍ Y **Coverage on Child 3** Child 3 Name_____ Child 3 Benefit $ _____]

Level Term Life

Office use only Group # Benefit # Class # Div #

[❍ Level Term Life] [❍ N ❍ Y] [**Coverage type:**] [❍ Employee / Individual only] [❍ Spouse] [❍ Child(ren)] [❍ No Coverage]
[**Base Plan:**][❍ 10 Year Term] [❍ 20 Year Term]
[**Optional Benefit:**] [❍ Automatic Benefit Increase]

[Employee / Individual Benefit $, .00] [Spouse Benefit $, .00] [Child(ren) Benefit $, .00]

[**If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?** ❍ N ❍ Y]
[If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
[❍ You (employee / individual)] [❍ Spouse] [❍ Dependent] [Name_____]]

Term to 95

Office use only Group # Benefit # Class # Div #

[❍ Term to 95] [❍ N ❍ Y] [**Coverage type:**] [❍ Employee / Individual only] [❍ Spouse] [❍ Children] [❍ No Coverage]

[Employee / Individual Benefit $, .00] [Stand alone Spouse Benefit $, .00] [Stand alone Child(ren) Benefit $, .00]

Last name: First name:

Critical Illness Expense

Office use only Group # Benefit # Class # Div #

[❍ Critical Illness] [❍ N ❍ Y] [**Coverage type:** [❍ Employee / Individual only] [❍ Employee / Individual and spouse]
[❍ Critical Illness and Cancer] [❍ N ❍ Y] [❍ Employee / Individual and child(ren)] [❍ Family]

[Optional Benefits:] [❍ Automatic Benefit Increase] [❍ Health Screening] [❍ Return on Premium]

[Employee / Individual Benefit
$, .00]

[**Have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?** ❍ N ❍ Y] [If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent. [❍ You (employee / individual) [❍ Spouse] [❍ Dependent] [Name_____]]

Group Lump Sum Cancer

Office use only Group # Benefit # Class # Div #

[❍ Group Lump Sum Cancer ❍ N ❍ Y] [**Coverage type:** [❍ Employee / Individual only] [❍ Employee / Individual and spouse]
[❍ Employee / Individual and child(ren)] [❍ Family]

[Have you or any dependent had a parent, brother, or sister with a history of cancer diagnosis prior to age [1-100]? ❍ N ❍ Y]
[If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.
[❍ You (employee / individual)] [❍ Spouse] [❍ Dependent] [Name_____]]

Rider:] ❍ Automatic Benefit Increase] [❍ Health Screenings]

[Benefit
$, .00]

Cancer Expense

Office use only Group # Benefit # Class # Div #

[❍ Cancer Expense] [❍ N ❍ Y] [**Coverage type:**] [❍ Employee / Individual only] [❍ Employee / Individual and spouse]
[❍ Employee / Individual and child(ren)] [❍ Family]

[Base Benefit
$, .00]

[❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount)] [**Rider:**] [❍ Hospital Indemnity Base Benefit Rider]

Supplemental Health

Office use only Group # Benefit # Class # Div #

[❍ Supplemental Health] [❍ N ❍ Y] [**Coverage type:**] [❍ Employee / Individual only] [❍ Employee / Individual and spouse]
[❍ Employee / Individual and child(ren)] [❍ Family]

[**Plan type:**] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6] [❍ 1-6]

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary
Last name First name MI

Relationship to employee / individual

Secondary beneficiary
Last name First name MI

Relationship to employee / individual

Last name: First name:

Evidence of Health Status

This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [medical,] [disability,] [life] [or] [workplace voluntary benefit] coverage.]

[[Long Term Disability] [and] [Short Term Disability] if the following criteria applies:]

[1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]

[1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]

[1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]

[1-8.][Within the past [1-12] months have you or, if applicable, your spouse, applying for coverage used any tobacco product? If yes, please indicate whether this answer applies to you (employee /individual) or your spouse ❍ Employee / Individual ❍ Spouse	❍ N ❍ Y]
[1-8.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y]
[1-8.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems], strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y]
[1-8.] [Have you or any dependent been diagnosed or received treatment for [an immune system disorder (i.e. Lupus, ITP),]AIDS or an AIDS-related complex?	❍ N ❍ Y]

[1-8.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]

[[a-o.]	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90 or above)]?	❍ N ❍ Y]	[[a-o.]	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y]
[[a-o.]	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y]	[[a-o.]	Stomach, gall bladder, digestive, intestinal or colon disorders?	❍ N ❍ Y]
[[a-o.]	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y]	[[a-o.]	Rheumatoid arthritis[; [or] back disorders; or joint disorders]?	❍ N ❍ Y]
[[a-o.]	Emphysema; asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y]	[[a-o.]	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y]
[[a-o.]	End stage renal disease; disease of kidney?	❍ N ❍ Y]	[[a-o.]	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y]
[[a-o.]	Kidney stones; bladder?	❍ N ❍ Y]	[[a-o.]	Diseases of the eye, ear, nose or throat?	❍ N ❍ Y]
[[a-o.]	Male or female organs; or infertility?	❍ N ❍ Y]	[[a-o.]	Alcoholism or drug habit?	❍ N ❍ Y]
[[a-o.]	Cancer, and/or cancerous tumor[; including skin cancer]? (state type & part of body in details section below)	❍ N ❍ Y]			

[1-8.] [Has any proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	❍ N ❍ Y]
[1-8.] [Within the past [1-5] years, has anyone enrolling or applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y]
[1-8.] [Are you or any dependent to be covered pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date:_____]	❍ N ❍ Y]

If you answered "yes" to any of the questions above, please provide details below and specify the question #.
Attach additional signed and dated sheets (reorder AR-51340-MH) if necessary.

Question # & Letter | (Person Treated) Last name | First name | MI

Condition | Treatments received

Medications prescribed | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) / / | Date last seen by a doctor (MM/DD/YYYY) / /

Last name: First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):

[Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Voluntary Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Group Term Life for:	❍ Myself]		
[Short Term Disability for:	❍ Myself]		
[Long Term Disability for:	❍ Myself]		
[Health Savings Account for:	❍ Myself]		
[Flexible Health Account for:	❍ Myself]		
[Flexible Dependent Care Account for:	❍ Myself]		

Waive Coverage for Workplace Voluntary Benefits:

[Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Term to 95 for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Critical Illness Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)]
[Disability Income Plus for:	❍ Myself]		
[Disability Income Advantage for:	❍ Myself]		

I decline to apply for group coverage because of:

[❍ Spousal coverage]
[❍ Medicare supplement]
[❍ Individual coverage]
[❍ Coverage under another carrier's plan provided by my employer / group]
[❍ Other:

_____]

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.

Last name: | First name:

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Large Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate

Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal representative signature

Date ___ ___ / ___ ___ / ___ ___ ___ ___

Name and relationship of legal representative (if a covered dependent) _____

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ County _____ State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/01/2012
Comments: see below			
Attachment: KIC readability.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/01/2012
Bypass Reason:	na		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	05/01/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	05/01/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	05/01/2012
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number:	*HUMA-128309463*	*State:*	*Arkansas*
Filing Company:	*Kanawha Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-12-006 KIC WVB*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Applications (KIC) WVB*		
Project Name/Number:	*SB Life Enhancement/AR-12-006 KIC SBE*		

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability	Approved-Closed	05/01/2012

Comments:

see attached

Attachment:

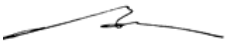
Statement of Variability.Application.pdf

KANAWHA INSURANCE COMPANY

CERTIFICATE OF READABILITY

RE: GROUP INSURANCE APPLICATION FILING
KANAWHA INSURANCE COMPANY
NAIC # 119-65110 (KIC)
Filing # AR-12-003 KIC SBE

I, Gerald L. Ganoni, an officer of Kanawha Insurance Company, hereby certify that I have authority to bind and obligate the company by the filing of these forms. I further certify that, to the best of my knowledge, information and belief, the above stated forms do meet the Flesch reading ease test achieving a minimum score of forty (40).



Gerald L. Ganoni, Vice -President

April 26, 2012

HUMANA.
Guidance when you need it most

Statement of Variability for Application Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.

2. Bracketed sections are identified by green brackets.

   NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.

4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.

   - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.

5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.

   - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.

   - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.

2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.

3. Bracketed numbers will include the minimum and maximum ranges.

4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

Bracketed Questions

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).

2. Any bracketed variables within that question are subject to change.

3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.

2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements

2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
    - prior approval of certificate or policy forms for the new products or benefits; and,
    - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.

2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.

3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.